

1 MR. FAST: Those would be in
2 a normal pathway from the personnel airlock to the reactor
3 vessel head, would be a normal point of egress for the
4 containment building. So, it would be expected those would
5 be in a normal line of sight, if they would have been
6 identified.

7 MR. GROBE: Was it acceptable
8 that auxiliary operators and other personnel that traverse
9 this area, that they wouldn't notice that corrosion through
10 all this?

11 MR. FAST: Jack, what I can
12 tell you, it was certainly not acceptable for me, for our
13 team; and I have certainly taken the managers in
14 containment and shown them those areas, as well challenged
15 our managers and our leaders at the plant to go in and look
16 at the reactor vessel head. A group of 17 of us went into
17 the vessel, so we could see the condition of the plant.

18 An important part of learning the proper standards
19 for operation is getting out in the field and looking.
20 That is my expectation and is part of our action to work
21 toward.

22 MR. GROBE: I think that's
23 very important; what I refer to as a teachable moment.

24 There was another one recently that concerned me.
25 Again, it involved your operators and decisions on

1 operability. This had to do with a through hole, pinhole
2 leak in an elbow, one-inch line that came off of your KE
3 removal piping. I think it's roughly a 14-inch pipe with a
4 one-inch line and it was a small pinhole leak from an
5 elbow.

6 It was a situation where the leak had begun and was
7 noticed, and that was great. Again, I want to understand,
8 the operators initially concluded that this problem doesn't
9 affect operability. And then later on, your engineers got
10 involved and concluded that it did in fact affect
11 operability.

12 Could you help me understand what role the engineers
13 had in the initial decision on operability and how you got
14 the situation where your operators called it one day
15 operable and engineering came back a couple days later and
16 said huh-hu.

17 MR FAST: There is a bit of
18 a case study there, Jack. That was initially identified,
19 it's a crack in a weld, not actually a pinhole leak through
20 an elbow.

21 MR. GROBE: Okay.

22 MR. FAST: And it was
23 identified as a minor leak by a nonlicensed operator on
24 rounds, which we, the behavior that we expect; they're
25 identifying those problems. A condition report was

1 written. And the operation staff, which has license
2 responsibility, made the call, or asked for engineering
3 help as appropriate.

4 Our licensed operator staff did not ask for
5 engineering help. Based on the review that was done in the
6 initial estimation of the leak, it was minor in nature;
7 however, it did progress fairly quickly.

8 We subsequently asked for engineering to help in the
9 determination of what the operable condition was and we
10 subsequently declared that area inoperable.

11 Does that as well meet our standards of excellence?
12 I will tell you that those are as well, teachable moments.

13 MR. MYERS: We thought
14 initially when discussing this leak, we said it was very,
15 very small. And if there was any increases in
16 significance, we were to immediately declare the system
17 inoperable. Is that correct?

18 MR. FAST: That is correct.

19 MR. MYERS: I think that's
20 what we did.

21 MR. FAST: As well I know
22 that our operations manager personally went out with the
23 shift manager and evaluated the condition real time as it
24 was identified; as well through our normal communications
25 process, I was notified of the condition.

1 MR. GROBE: When you said this
2 was another teachable moment, how did you use this as an
3 example?

4 MR. FAST: It's opportunity
5 to build conservatism into the, what we would like our
6 shift managers to understand is that we have a team of
7 people at Davis-Besse that can support one another, and no
8 one individual should bear complete responsibility without
9 gaining input from others.

10 And so, although by license, the senior reactor
11 operator, the shift manager is responsible for the
12 operability call, our expectation is that the team work
13 together to resolve issues and make the best
14 determination.

15 MR. BERGENDAHL: We've built in
16 checks and balances, so that we know when anybody has to
17 make calls like that, there is a follow-up and review by
18 the management team and the engineering staff.

19 MR. MYERS: For example, that
20 morning I think we went back and put the hatch back on,
21 didn't we?

22 MR. BERGENDAHL: We took several
23 actions.

24 MR. MYERS: We took several
25 actions as soon as we found that situation. As I say,

1 we're more conservative now for that reason.

2 MR. ESHELMAN: That was a very
3 good teachable moment for that management team. It was
4 during that meeting where the challenge came, specifically
5 Lew was very involved with the challenge and the team
6 learned to ask very good questions. The shift manager and
7 operator, they were involved. And, I think we all learned
8 a lot from that situation.

9 MR. GROBE: May have created a
10 nightmare with this teachable moment. It's a phrase I use,
11 and I believe firmly. I'll just give you another
12 Jack-ism.

13 My view of the plant's operation is like a bus;
14 there's engineering and maintenance, and everybody is their
15 support operations to make sure the plant is safe.

16 In just a week and a half or so, I haven't drawn any
17 conclusions, but I came across two examples where it's not
18 clear to me that operations got the best advice it could.
19 It made a decision in one case that was not conservative,
20 where they called the equipment inoperable and engineering
21 came back a couple of days later and said they couldn't
22 support that conclusion.

23 Another case, containment vessel, they called it
24 operable and the decision is still out on that. I don't
25 know if they had enough information on that point to make

1 that determination.

2 So, I'm a little concerned. And we'll continue to
3 be focused around this.

4 MR. BERGENDAHL: At this point in
5 time, we are scrutinizing every activity. We have a lot of
6 oversight and looking at everything we do as well.

7 MR. MYERS: I will tell you
8 too, from a management standpoint, from a department
9 standpoint, or cross-discipline and office, if you will; we
10 will tell you now that needs improvement. Getting that
11 engineering support is a good example; just a matter of
12 picking up the phone and calling someone in.

13 MR. MENDIOLA: Going back to the
14 plant, for a second, I would like to discuss the
15 completeness of the tasks of the extent and the condition
16 of the plant. Targets seem to be focused primarily on
17 those containments in the plant not susceptible to boric
18 acid corrosion.

19 I've expressed, and you've discussed a few already,
20 I'm interested in finding out if you had increased or could
21 you increase your target list to include those targets
22 which would be affected by corrosion, which would
23 be steadily affected by operation by the material played
24 out, if you will, on working components, moving components;
25 that, or even electrical components. I'm talking

1 conduits. I'm talking cable runs. All those topics. That
2 doesn't seem to be in the targets list. And I was
3 wondering how you were going to address that?

4 MR. FAST: We've made some
5 recent, based upon feedback, from our oversight panel as
6 well, by collecting lessons learned from D. C. Cook, we
7 know that our issues with qualification, order operated
8 valves, surface coatings and whatnot, and those will be
9 revised into our plan.

10 MR. MENDIOLA: Into this part of
11 the plan?

12 MR. FAST: Yes.

13 MR. GROBE: Other questions?

14 With that, I'll turn it over to Jim Powers.

15 MR. POWERS: I'm Jim Powers,
16 Director of Engineering. I'm a new member of the
17 management team at the site. I'm going to talk about the
18 technical compliance plan for programs.

19 And, programs are what we use to run the site.
20 Programs consists of procedures and instructions and people
21 that follow them and make the programs run. Similar to
22 when you buy a new car, you get an owners manual and there
23 is a maintenance schedule in there. Comparable program
24 would be that's the instructions. You have trained
25 mechanics at the shop that, to carry out that maintenance;

1 and the training of those mechanics. It's a complete set
2 of activities that maintain your car.

3 We have similar programs in the plant to maintain
4 the plant and documentation of the plant. And what we're
5 going to do is a systematic review of plant programs for
6 ownership and industry standards.

7 And, why is that important? Well, programs are
8 what is involved in maintaining, for example, our
9 reactor vessel for boric acid inspections containment; a
10 number of things that are involved with the issues here
11 today.

12 So, we have gone through and identified 60
13 programs. They're largely technical programs that are
14 dealt with in the engineering areas, technical areas of the
15 plant, extending through how we test the equipment, how we,
16 for example, prepare calculations and maintain them; how we
17 maintain our circuit breakers. So, that's 60 major
18 programs we're going to be evaluating and we're doing that
19 now.

20 I sit through review processes with the program
21 owners. We ask them to come in and describe their program,
22 describe the continuity that they've had the ownership on
23 the program, what their qualifications are, and what
24 improvements they've made in their program recently, what
25 problems that they are wrestling with, where they need

1 assistance by management to improve their program.

2 And, we're finding out a number of interesting
3 things. We see a spectrum of, of results in the review;
4 everything from having the industry leader as program owner
5 in a particular area, such as steam generators, to having
6 someone who is relatively new to the program and needs some
7 assistance, is getting trained up on it, getting qualified.

8 And in those cases, we identify what's needed in terms of
9 additional oversight or training, additional
10 qualifications.

11 So, it's a very good process for me and my managers
12 to see what's going right, what's not going right and what
13 needs to be done to improve those areas that need
14 improvement.

15 There is five programs out of this set of 60 that
16 we're going to be looking at in a large amount of detail.
17 And these are the programs that were involved in some
18 aspects with the corrosion of the reactor vessel head. And
19 they're listed on the slide here.

20 The Boric Acid Corrosion Control Program, we
21 referred to discussion on inspection of systems that
22 contain borated water. Leakage out of the systems can
23 cause corrosion on the components that are leaked on. So,
24 we're looking at that in quite a bit of detail.

25 Also the Inservice Inspection, because there are

1 hand-offs and relationships between programs. The
2 inspection program for Inservice Inspection looks at
3 pressure vessels. It needs to be linked up tightly with
4 Boric Acid Inspection Program, which also looks at pressure
5 vessels.

6 Corrective Action Program is very key to us at the
7 site to identify our problems and effectively resolve them.
8 So, this is one of the first ones we're going out of the
9 shoot with, the detailed review on. That will be starting
10 up the coming week.

11 Operating Experience, because we need to learn from
12 our peer nuclear power plant stations around the country,
13 and the world for that matter, lessons learned. It's best
14 to learn those lessons from others, incorporating them into
15 our operating philosophy, so we don't have to learn them at
16 the site ourselves. We want to look at that to see what
17 its health is, and whether we're effectively incorporating
18 them in our experience.

19 And the last one we have on the detailed review is
20 Modification Process, and this is a process identifying
21 problems at the plant. We want to improve performance of
22 our equipment of our physical plant. We go through the
23 Modification Process and that's a very controlled process,
24 to make sure we maintain the design basis and we achieve
25 the results that we desire.

1 MR. DEAN: Jim, can you
2 describe, I guess, the difference of the delta between how
3 you're going to incorporate these major programs and what's
4 incorporated in this detailed review? I have trouble with
5 understanding this.

6 MR. POWERS: The initial review
7 is what we've asked the owners to come in with a
8 description of the program and its scope and what their, we
9 get a sense of what their expectations are, their
10 understanding of the expectations are, relative to the
11 extent of their ownership, that scope.

12 For example, do they have a responsibility for the
13 training of the people that implement their program? And,
14 so, it's a broad questioning process that we go through.
15 We look at the qualifications continuities I had
16 mentioned.

17 We also look at how they incorporate the industry
18 experience, what recent problems they have with their
19 system, ongoing problems, any issues that they've got and
20 haven't been resolved; and improvements, and when was the
21 last time they availed themselves of self-assessment and
22 how recent was that.

23 So, that gives us a sense of the health. We're
24 going through all 60, asking back level of questioning.
25 And that gives us a pretty good sense of where we need to

1 prioritize our attention going forward.

2 The five programs, we're going into a much more
3 detailed level of review, not just, not just interviewing
4 the owner, we're setting in place teams with independent
5 industry, consultants, assisting us on the teams to go
6 through the program in detail out to all the areas of the
7 plant activities that it extends to assure that it's
8 working appropriately, and look for areas of weakness and
9 areas of strength, and identify actions that are required
10 to improve and upgrade the program.

11 So, the detail will be done initially on the five,
12 but as we see areas of weakness, as we go through the total
13 60, we'll be prioritizing those to be reviewed as well.

14 So, it's not just a one time through on the 60.
15 It's basically just telling us where is our strengths and
16 weaknesses are.

17 MR. MYERS: Let me comment on
18 that too. We looked at some other programs at other
19 plants; and the 60 programs that we're going through, we
20 think that that level detail is, is about where the other
21 plants stop. We believe this latent issues program or the
22 five we're going through, we may add some to that.

23 We got from our Beaver Valley plant, called a late
24 issues problem, we have the same person up here helping
25 with that. And that's been a major contributor to, we

1 think, improving performance of the Beaver Valley station.

2 So, we think this is over and above what we've
3 typically seen in this industry so far. So, we're pretty
4 pleased with that.

5 MR. JACOBSON: Jim, I've taken a
6 look at your program document and I think there is a couple
7 things that are not very clear to me. The portion is
8 entitled, Plant Program Assessment, the initial reviews;
9 who is doing the assessment; program owner that's putting
10 this report together or program review committee?

11 MR. POWERS: The program owner
12 puts the report together. We have the sections that are
13 described, content that he needs to address, that I've
14 talked about. He brings that in and he brings along his
15 supervisor as well. And then the committee, having
16 reviewed that report, walks through it and asks questions
17 to sound out what areas, other areas of weakness are there
18 potentially that we need to address, get a sense of what
19 needs to be done for that program to, to improve and make a
20 strong upgrade to it.

21 And we also issue corrective action documents, areas
22 where we find out that it's not meeting our expectations
23 and we need to take actions. We come out of the meeting
24 issuing corrective action documents to capture that area
25 for improvement.

1 MR. JACOBSON: So, it's
2 essentially the committee that's doing the assessment?

3 MR. POWERS: That's right. The
4 committee does the assessment of the owner's report, and
5 through the interview process of the owner.

6 MR. JACOBSON: You have things in
7 here that you're going to be looking at, like appropriate
8 interfaces with other programs, and clear roles and
9 responsibilities, but I look at the top of the report and
10 it says, include reference to procedures, guidelines and
11 define related roles and responsibilities. I don't see any
12 of the assessment going on here. I just wondered where
13 it's going to happen?

14 MR. POWERS: Well, the
15 assessment happens in the interview process. We can ask an
16 individual to list out the procedures of what we want to
17 look at is. If it says that there is an interface, another
18 individual program needs to link up, and have a hand off,
19 we ask how is that going, who is responsible, how much
20 responsibility do you have once that goes into that other
21 interfacing program; is it still your responsibility of the
22 ownership. To carry that forward and bring it up to our
23 attention if there is a weakness there.

24 So, through the questioning process, we can usually
25 find out how is the program really working, because we're

1 going to have it laid out well in procedures, but we really
2 have individual ownership and oversight, standards and
3 situating process, and all of this, to make sure that it's
4 working the way it should.

5 We find that out pretty well by interviewing the
6 individual, just asking him questions on how he's doing
7 the, what he's doing.

8 MR. JACOBSON: One of the
9 objectives of your, looking at your summary, executive
10 summary; review of engineering programs and other plant
11 programs as a result of information that would cause the
12 reactor head damage. Contributing factors discussed,
13 included weaknesses in program ownership, program scope,
14 and management oversight.

15 Yet I look at this report, attempt it again, and
16 some of the questions there and I don't see anything about
17 management oversight in there. How are you covering that?

18 MR. POWERS: Well, that's
19 having me in the meeting, and my managers in the other
20 part, is one aspect of it, and find out what sort of
21 interface there has been with management with these
22 programs. Because oversight is a major piece that there
23 needs to be ownership, not only by the program owner, but
24 by the management of the program.

25 So, here are any issues that the program owners have

1 and remove barriers and help make that program successful
2 and strong. We get that as part of the questioning on it;
3 and I think that was written down here, as one of the, one
4 of the attributes we wanted to go through, as part of the
5 course that was initially done.

6 But when we do pick it up in the questioning process
7 of it; first cut, and we get into the detail review, it's a
8 piece that's going to be assessed. But, let me take that
9 comment and make sure I have that as strong as we need to.

10 MR. JACOBSON: As a reviewer, it
11 appears you're doing more than is reflected in your, well,
12 just picking it up and reading it, I don't understand how
13 you're doing some of this stuff.

14 MR. GROBE: On that same
15 point, Jim, are these program review board meetings or
16 committee meetings, are they like a certain day of the week
17 or something like that or is this ad hoc?

18 MR. POWERS: No, not ad hoc.
19 There is scheduled days. We schedule them, and based on my
20 attendance, and the attendance or availability of the
21 managers, there has been times we had to reschedule. So,
22 if you had interest in attending them, you can certainly
23 attend. We can notify you when we have them, but they are
24 prescheduled.

25 The attendance is expected. I'll be there;

1 managers, engineering managers will be there; Quality
2 Assurance Oversight is there, the program review owners,
3 Neil Morrison and Allen McAllister are there, as well as
4 the owner and supervisor. So, it's a consistent set of
5 people that attend these.

6 MR. GROBE: The reason I ask,
7 there is nothing wrong with this, given the dependance
8 you're placing on the committee to do reviews and
9 assessments, we're going to need to be there to observe it,
10 to observe them in action.

11 MR. POWERS: Okay.

12 MR. GROBE: So, we'll need to
13 understand when those are occurring, give us a chance to
14 see a couple of them.

15 MR. POWERS: Very well, good.

16 I'll make sure you're notified.

17 MR. GROBE: Not me. These
18 guys.

19 You raised a question in my mind that I wanted to
20 ask Randy. Sorry, and I'd forgotten.

21 One of the things that concerns me, and it only
22 concerns me because it's in question, and I don't have the
23 answer right now.

24 One of the important aspects of equipment inside
25 containment is environmental qualification of the

1 equipment. I have no idea whether this boric acid as most
2 fear affected the environmental qualification of the
3 equipment or not. It's a question that needs to be
4 answered, and you know, cable jack materials, slicers,
5 junction boxes, gaskets; how are you going about evaluating
6 that impact? You can't do that by visual inspection per
7 se. I don't think.

8 MR. POWERS: Well, our initial
9 approach is to document those issues for corrective action
10 process and go through and evaluate what needs to be done
11 to demonstrate environmental qualifications have been
12 maintained. And there will be inspections inside
13 electrical junction boxes, for example, as we determine
14 what the extent and conditions some of the E Q Components
15 are, hermetically sealed from the environment.

16 Others may have gotten some exposure to the boric
17 acid and we would ask a question on cable, potential cable
18 jacket degradation and there is other issues. That is on
19 our list of --

20 MR. GROBE: And the question,
21 regarding the question itself, but the hermetic seal and
22 whether or not it still has maintained its qualification.

23 That was a question for you Randy and Jim answered
24 it.

25 MR. MENDIOLA: Are these

1 reviews, look at the past information; that wasn't real
2 clear.

3 MR. POWERS: When you say past
4 information?

5 MR. JACOBSON: When you appear
6 to look at the program, you might look back and see how
7 it's working in the past. It's not real clear if that's
8 going on. I wondered what you had in mind?

9 MR. POWERS: The answer is yes,
10 particularly in the detailed reviews, we'll be looking at
11 how the program evolved, and what particular issues there
12 may have been with the program over the past. Corrective
13 action documents are signed in the program; other industry
14 operating experiences that may have been pointed out, we
15 say that our program may have been susceptible to.

16 That's a major piece. And you find out in the
17 interview process for the initial reviews, that typically
18 comes up.

19 Where is the area of problems? Has it been an issue
20 with the interface to other programs? That usually comes
21 out that they would, hasn't worked as well as they would
22 like, hasn't done it for a long time. Made it work, we
23 forced it to work, but it's not, has not worked as well as
24 it should or perhaps it's not working specifically as we
25 have written down, or maybe we don't have it written down.

1 And there is, the individuals are working from their
2 own knowledge, and we've got somebody with a long team
3 experience at the plant to program. And if they were to
4 leave, that little cog would be taken out of the machine
5 and no longer works.

6 So, our program is not complete. So, we're looking
7 for those types of areas over the longer term too.

8 MR. JACOBSON: One other question,
9 you've listed a group of the first ten programs that you're
10 going to review; and you've ranked them by lists; high,
11 medium and low. These ten, are these all high or is this a
12 mixture or are there more high in this? What are these?

13 MR. POWERS: Well, the first set of
14 programs are important to us. I would say, I'm not sure
15 that risk is the right term to be assigned to them, but
16 they're important to the function of the plant.

17 The five that I described or mentioned earlier on
18 that had some aspect of involvement in the reactor vessel
19 head issue. Certainly, we want to look at those
20 specifically, and they include some of the keystone
21 programs. We need to look at early corrective action,
22 because we're using corrective action, have used it,
23 continued to use it.

24 Key Stone Program. It's to solve problems,
25 Modification process. We also did a, an initial what I

1 call a model program review on our problem list, in
2 particular, safety assessment, PSA program to determine
3 itself; develop the report out on it, so we had a template
4 to go from in terms of establishing what the standard was
5 for these reviews.

6 So, that was a very another significant one, because
7 these days that's how we're managing the plant with a lot
8 of input from our PSA models.

9 So, there is a level of importance. I guess I could
10 say potential risk to operation of the program is how we
11 looked at those.

12 MR. JACOBSON: It's not
13 specifically then, as you said here, specifically
14 characterizing risk programs, there is sensitivity ranking
15 the programs. It's not, it's not really done by risk then?

16 MR. POWERS: Not by a PSA type
17 of risk, but I guess risk to the importance of the function
18 of the site.

19 MR. JACOBSON: And these ten
20 then, are they all in the high ranking? You have high,
21 medium and low. Can you tell me that?

22 MR. POWERS: I can't tell you
23 that right at the moment, but I expect they're in the high
24 range and I have to look at the details and get back to you
25 on that.

1 MR. JACOBSON: Okay, thanks.

2 MR. GROBE: Jim, you had
3 mentioned that, used of the word consultants. A lot of
4 this, effectiveness of these evaluations, the way you're
5 doing them, depends on the team, the review panel. And,
6 that's a strength, I think. But in the, what access are
7 you going to make of yourselves, what access are you going
8 to take to industry experts? Other plants might have best
9 practices in certain areas, tapping into that expertise to
10 assist you in these evaluations?

11 MR. POWERS: Well, there is a
12 couple of approaches we're using for that. One of the
13 things we do talk about with the program is what
14 benchmarking have they done. What is the best and have
15 they gone to see what that is. We need to see the best to
16 understand.

17 That's a piece of the review. But what we're doing
18 for obtaining a consistent best, we're obtaining consistent
19 expectations in review and we're retaining outside help,
20 self-help.

21 We sent the first couple of individuals that we
22 brought in through the PSA model review. So, they've gone
23 through that. We're working out what the expectations are,
24 making sure we understand what the level that we want them
25 to go to detail is understood. And there is two of those

1 individuals and we're breaking them out into parallel
2 training as we go through corrective action process and
3 boric acid patrol process, so they'll carry forward on
4 continuity, here's what that expectation is, and have that
5 in place as we bring on several more individuals to beef up
6 our teams and assist us.

7 MR. GROBE: These are people
8 from outside your organization?

9 MR. POWERS: That's correct.
10 These are people outside the industry, consultants and
11 assistants.

12 MR. GROBE: That have specific
13 expertise in boric acid or corrective action or expertise
14 in assessing?

15 MR. POWERS: Yes, in some
16 cases, or they have the rounded depth of background that
17 they know where to probe for problems. Many consultants
18 there worked with corrective action. At many sites they've
19 seen good and they've seen bad. They bring that experience
20 to the table.

21 MR. HOLMBERG: The question on
22 the scope of your programs that you initially selected, the
23 one area that I didn't see in there, I don't know if it was
24 considered, is the role of the Quality Assurance
25 Organization and their role in audits and so forth. And,

1 obviously, they have some, some part to play in terms of
2 whether or not they need to learn a lesson, if you will, or
3 have some opportunities coming out of the original head
4 degradation issue. So, I want to know if you could speak
5 with respect to those organization?

6 MR. POWERS: Certainly the role
7 of quality assurance is to provide oversight and point out
8 areas in the organization where we are weak or need areas
9 of improvement; and they, they are participating in these
10 program reviews in the oversight function. I think going
11 through that process in itself is raising the standard in
12 terms of what the expectations are; getting a lot of very
13 probing issues from them, a lot of corrective actions is
14 being generated.

15 So, I think that the process itself is providing
16 improvements in that area, in the quality assurance area.

17 MR. ESHELMAN: I would like to
18 add to that. In my program, Management Human Performance,
19 that's a specific line item to look at the quality and
20 oversight organizations; how the, how the effect was; what
21 we need to do to improve it.

22 We have a new Vice President of Oversight. He's
23 chartered to commission a team to look at the oversight
24 organization, the role they play in this issue. It is not
25 in the program, it's in my area.

1 MR. MYERS: And the other
2 thing, we created a vast presence of oversight now. You've
3 asked for oversight. Additionally, if you look at our
4 Oversight Review Board, once again, if you look at the last
5 time, we're sponsoring an independent self-assessment on
6 the interactions of the oversight groups toward this whole
7 issue.

8 So, we'll be doing an assessment of quality and
9 assessment of our CRB, how it all -- why don't we pick it
10 up there; that's the independent assessment we're
11 sponsoring. Looking at bringing in an industry expert on
12 that too, so I know who that is already.

13 Does that answer your question?

14 MR. HOLMBERG: Yes. I guess I
15 was, what I heard in your discussion was basically you're
16 anticipating you're going to learn from the ongoing effort
17 and then you've got some other efforts in your management
18 and self-assessment areas that you're going to pick up key
19 roles in that. That's what I just heard, I believe.

20 MR. MYERS: Exactly. How did
21 our oversight roles not pick up this issue also. I mean,
22 that's the question, and we need to assess that.

23 MR. HOLMBERG: Right.

24 MR. MYERS: Okay.

25 MR. POWERS: Okay, that

1 describes what we're doing for our program reviews. Any
2 other questions on that?

3 MR. MENDIOLA: I had a question.
4 Primarily has to do with the summary, if you will, at the
5 Davis-Besse Return to Service Plan, discussing specifically
6 this area.

7 There is a lot of reliance on the entire table of
8 when the items are going to get done and by who, relating
9 to plant restart. Excuse me for reading, but basically
10 says, prior to restart detailed review, five programs will
11 be performed following plant restart, complete reviews of
12 the remaining programs are on the list.

13 As I understand from what you just indicated, I will
14 indicate 55 programs which were formed following plant
15 restart, but further down in the discussion it talks about
16 previous start review can be done for the five programs,
17 only on portions of those five programs.

18 The important portions it talks about. And that
19 those would be implemented prior to restart and then
20 additional reviews would be done as you mentioned based on
21 ability -- I mean, I'm sorry, risk on plant liability and
22 safety.

23 I'm a little confused over when actually all these
24 programs will get done, if you're indicating it to plant
25 restart.

1 MR. POWERS: The schedules we
2 have for the reviews are in the plan. I know you're citing
3 there from the restart readiness plan. In the specific
4 plan we show timelines and program reviews. They'll be
5 done in August, the August time frame. So, it tends to go
6 in detail.

7 MR. MENDIOLA: The 5 or 60?

8 MR. POWERS: The 5. The 60
9 will be continuing on. We will look through all of those
10 60, intend to review all 60 programs for the additional
11 review prior to restart, but as part of the process of
12 doing that review will give us prioritization on areas
13 where we want to go for detailed review and how we schedule
14 that.

15 What is detailed priority? Some of those areas we
16 find a weakness. We want to do a dry restart, that could
17 be the case. That's what we're looking for as we go
18 through our programs.

19 MR. MENDIOLA: Then that
20 statement, then based on need, and it could, the program
21 could be elevated up the list, if you will, to a higher
22 priority.

23 MR. POWERS: Yep, yep.

24 MR. MENDIOLA: But the core five
25 then, the first five, as I understand it, will all be done

1 prior to being prepared for restart?

2 MR. POWERS: That's right.

3 MR. MYERS: Should we find
4 something else broke, don't look good, we'll deal with it.

5 MR. MENDIOLA: I understand.

6 MR. GROBE: Any other
7 questions?

8 Lew, we've been at it for an hour 45 minutes. I'm
9 looking at the rest of the slides. I'm wondering, I think
10 we've had a chance to look at the system. Now the plans.
11 I would like to talk about that one and I would like to
12 talk about Management and Human Performance.

13 I'm not sure we've all had on this side of the table
14 an opportunity to review in detail Restart and Post-Restart
15 Plan and Restart Action Plan. Should we defer those to a
16 later meeting?

17 MR. MYERS: That was my
18 thoughts.

19 MR. GROBE: Okay, let's go on
20 then with the System Health Assurance Plan and then get
21 into Human Performance and maybe call it a day.

22 MR. POWERS: Also with respect
23 to System Health Assurance Plan. This consists of a
24 three-phase approach that we're adopting for the systems.

25 And, the first phase is complete, and that was an

1 operational readiness review of safety and reliability
2 systems. This was done over the past about a month, month
3 and a half. Randy Fast led this up.

4 This was again similar to the program review. This
5 was an initial review of system health, asking the
6 responsible system engineers to come in and talk about
7 their system, looking at what improvements had been made,
8 what problems do they have for their system, what
9 modifications that they are striving to get done on their
10 systems, and perhaps having problems getting prioritized
11 and completed; what corrective actions have had problems
12 with their systems, and get a general sense of how the
13 system health and system engineering and provide an
14 opportunity for them to speak to management about what they
15 want to get done to improve their systems.

16 And Randy served as the leader and champion of that
17 for the NRC. And the Phase II is a comprehensive review of
18 30 systems.

19 MR. MYERS: Can we stop right
20 there?

21 Again, our Phase I, Randy led. That phase right
22 there was all directly after -- so they stopped there, did
23 those two phases over and above what we've seen elsewhere.
24 So, once again, it shows how comprehensive our plan is.

25 Isn't that correct, Randy?

1 MR. FAST: Yes, sir.

2 MR. MYERS: Go ahead.

3 MR. POWERS: And I'll talk

4 about it in more detail on the following slides on these,

5 just briefly the definitions.

6 Phase II is a comprehensive review of 30 systems

7 that are based on risk and performance that comes from our

8 PSA risk models. These are 30 models that are risk

9 significant to the plant. A comprehensive review is just

10 that, outlining some details in the following slides.

11 Phase III is what we call Latent Issues Review. And

12 we selected three items to do a Latent Issues Review. And

13 this is something that we started at our Beaver Valley

14 Plant and follows through and is done in our Perry plant.

15 It involves a team working on a system for six

16 weeks, sometimes up to eight weeks, studying all the

17 details in a system from the past. They look at

18 maintenance work orders, which are the record of work done

19 on a system. They look at corrective action. They look at

20 industry experience on a system. They look at design basis

21 of a system.

22 It goes into a lot of detail, and particularly this

23 is where we link up into the design basis maintenance and

24 its application, use and surveillance of the plant, the

25 surveillance of structures to be sure that the total

1 picture is sound.

2 The three systems we selected for that level of
3 review are the reactor coolant system, because that is
4 central to our core issue today; emergency diesel
5 generator, because they are our emergency power supply,
6 very important to the plant safety; as is the auxiliary
7 feedwater system, which provides cooling to the reactor
8 system during the plant upset.

9 And, these are areas that we feel are important to
10 go into the very high level of detail. And there will be
11 teams again led by industry specialists, consultants, to
12 supplement our staff and provide outside perspective to
13 these reviews to staff these, be sure that they get done
14 promptly. And they're gearing up to start now, and again
15 in the next several weeks.

16 The next slide shows the result of the initial Phase
17 I, the Operational Readiness Review. The results is System
18 Engineer came to Randy and said, you know, I've been trying
19 to get this pump replaced and it's been installed in the
20 budgeting process for several years now, and it's still
21 there to be done. And we took action on that.

22 John Messina here is the Chairman of what we call
23 Project Review Committee, which manages the funds for the
24 site, the site budget. We bought these projects as
25 resulted from the System Readiness Review and Project

1 Review Committee and authorized funding.

2 We're doing work now on the plant. This is a
3 typical example of the type of work that does get done to
4 improve the system of the plant; new pump, refurbished
5 pump, valves, motors, things that need to get done, and
6 we're pushing those through now.

7 There is a lot of activity and there's going to be a
8 lot of activity for engineering, as you can imagine, for a
9 lot of the modifications that are on too. Now they've been
10 authorized to get it done. This is another set of plans to
11 do that. We're arranging that support.

12 Phase II then, going on to slide 24.

13 Comprehensive Review is looking backwards to see how
14 the system has been doing in the past. And we're looking
15 back 7 to 12 years.

16 In the case of condition reports, we're looking back
17 to 1995 time frame. In the case of modifications, we're
18 looking back to 1990 time frame. And these we feel are
19 significant milestone flags when there may have been
20 changes to the site management occurring that could have
21 softened some changes in practice at the site that led to
22 potential issues development.

23 Modifications in particular; we looked at the
24 modification that had been proposed to the service
25 structure and for access to inspect the reactor head. And

1 that modification was, was deliberated on in terms of how
2 necessary was it.

3 There wasn't an understanding about the issue with
4 the boron corrosion mechanism at that time. So,
5 modification was not done properly. Now it has been done.
6 But we're looking back at all the modifications; the ones
7 that have been done and ones that haven't been done to see
8 if the right things have been done for the systems.

9 Same thing with condition reports. Did we get to
10 the heart of the problem and solve it or did it recur. Did
11 we carry out with corrective actions as written.

12 So, it's a comprehensive review looking at those
13 areas. Includes system walkdowns to physically go look at
14 the system, make sure there is no surprises to the review
15 of the documentation not uncovered.

16 MR. JACOBSON: What's the
17 scheduled times then for these various phases?

18 MR. POWERS: The comprehensive
19 reviews will be done prior to the restart, and detailed
20 reviews will be done also. The comprehensive reviews will
21 be headed up by the individual system mentioned here. It's
22 one system we know the most about it. They'll be
23 supplemented by outside specialist consultant assistants to
24 get it done.

25 We're also arranging groups like corrective action

1 team, qualified level group that can help go through the
2 corrective actions associated with the systems and make
3 sure there is a common high standard of review of
4 corrective action history on it. So, that's all the prior
5 to restart activities.

6 Once again, comprehensive review indicates
7 significant problems with the system that's not currently
8 scheduled for the Latent Issues Review, go into Latent
9 Issues Review on that too. So, here's an opportunity to
10 dipstick the health of a system and proceed from there if
11 we find areas requiring further review, but this gets an
12 idea of the Latent Issues Review scope.

13 Compliance with design basis documents, identifying
14 the design functional requirements, confirm required
15 functions are met, provide action as persist in document
16 improvements.

17 One of the areas that we've been working with over
18 the years at these nuclear plants as they were designed and
19 constructed in the 70's, early 80's, a contractor
20 engineering organization prepared the calculation and
21 analyses of support that designed the plant.

22 Then they turn it over to us to run the plant. As
23 we move forward with time, we find areas that need
24 improvement, modifications are made, reanalysis is done,
25 design basis of the plant has changed. Important industry

1 initiative to make sure the design basis is maintained and
2 is updated and maintained strong.

3 So, this latent issue really goes after that. So,
4 if we have a calculation that says a pump should provide so
5 much flow, we go to our test instructions and make sure
6 they also test the pump to derive that much flow and the
7 process is linked well together to demonstrate the system
8 performance.

9 The results of the latent issues review will be
10 independently reviewed. As with many of these products,
11 not only are they prepared by outside consultant support,
12 independent brought in that way, but then we have an
13 separate engineering board that's been assembled. It's
14 going to be reviewing these engineering products and
15 critiqueing them prospectively, to be assured that they've
16 answered all the questions that would be outstanding on a
17 system, and the quality of review is consistent with what
18 we expect or require.

19 And these will be completed prior to restart, the
20 three systems I have listed there.

21 Is there any questions on that?

22 MS. COLLINS: I have a couple of
23 questions that you didn't answer in your presentation.

24 The first is, it looks like each of these phases
25 will generate perhaps restart issues. I was going to ask

1 about the results of your Phase I and you presented that.

2 Is that your only restart issue out of your Phase I
3 review, that high pressure injection pump replacement; or
4 do I not understand that?

5 MR. MYERS: Go to page 35 of
6 your handout. Why don't you flip through. That was part
7 of our presentation.

8 MR. BERGENDAHL: What happens in
9 these plans, we generate work orders, condition reports,
10 modifications. When you review the plan, the system in
11 this case, identify actions to be taken. Write the
12 conditional report. That conditional report gets reviewed,
13 and it will be performed prior to restart, unless the
14 review board determines that it does not meet any criterion
15 and can be done safely at a later date.

16 MS. COLLINS: So, the results of
17 Phase I would there be other condition reports that have
18 been generated that are prior to restart in addition to the
19 pump replacement project that you just discussed here?

20 MR. BERGENDAHL: And the pump
21 replacement project is something we had done in the
22 outage. There was motor replacements and modifications
23 that were identified as things that came out of that
24 initial review that we decided to do prior to restart.

25 All of the outputs are adapted by the board that

1 determines whether or not it will be done prior to
2 restart.

3 MS. COLLINS: So, that was
4 probably the most major item out of Phase I, the System
5 Health Assurance?

6 MR. FAST: Your work orders,
7 some training was identified, some procedure changes.

8 MR. POWERS: Also another
9 significant modification is, for example, our start systems
10 for emergency diesel generators. We had an ongoing rust
11 concern with the original one. And we've got some
12 significant projects that were approved to change out those
13 systems and put stainless steel pipe fitting and dryers to
14 improve them. Now those are scheduled to be done, I think
15 the first set is scheduled for November.

16 So, it's not specifically tied to startup, but it is
17 something that's, that is scheduled to get done; a
18 significant project scheduled to get done.

19 MS. COLLINS: A couple of other
20 questions. You say it includes system walkdowns and this
21 is just a follow-up on Scott's comment. That was not real
22 clear in the plan that system walkdowns were to be a large
23 part of this health assurance and kind of what other
24 walking around system is very general.

25 MR. POWERS: Well, they're

1 looking for overall system health. You can look for leaks,
2 any sort of degradation of gaskets, components, some of the
3 nonmetallic type of components in it, any maintenance work
4 that hasn't been completed, missing bolts. It's a thorough
5 walkdown.

6 One of the things we're doing, we identified this
7 ourselves, is as we get to this point, we need to provide
8 more specific instruction on exactly what are we looking
9 for and we want to get some of the individuals that have
10 been involved previously, for example, at the Cook Plant or
11 the Salem Plant, here to show us what they learned in their
12 system walkdown. So, as we go out for the first set, we do
13 it right the first time. And we'll be documenting on a
14 walkdown procedure with the attributes that need to be
15 checked off.

16 MR. THOMAS: Jim, comprehensive
17 review states that walkdown will be done where appropriate.
18 Will you clarify where appropriate is?

19 MR. POWERS: I think it's going
20 to be appropriate in every case where the engineer gets out
21 and walks down the system.

22 MR. THOMAS: One other thing.
23 Sorry to interrupt, Laura.

24 MS. COLLINS: Go ahead.

25 MR. THOMAS: Technical

1 compliance report tends to review the boric acid review
2 program. What's been done to date to raise the sensitivity
3 of engineering staff will be performing the system help
4 evaluations to the proper implementation of that program?

5 MR. POWERS: The Boric Acid
6 program, we have revised the Boric Acid Program to
7 incorporate improvements that have been identified from
8 industry lessons learned earlier this year, and went
9 through that process. And so, we incorporated those
10 improvements into the inspection of structures that the
11 engineers have been using.

12 So, those improvements are already, already
13 incorporated and now formalized in the program document
14 itself, and we will be continuing to improve that.

15 MR. THOMAS: You improved the
16 program and engineers will receive training on those
17 improvements; is that correct?

18 MR. POWERS: Right. That was
19 in the inspection procedures, so the engineers were trained
20 to do their inspections.

21 MR. MYERS: Our process is
22 maybe improved. First thing you do is a leads analysis;
23 systematic approach to training. And as you do that, you
24 train your people to new programs. So, that's part of our
25 process.

1 MR. THOMAS: Okay.

2 MS. COLLINS: One last question
3 on this plan. I know in the plan that I reviewed said that
4 the reactor coolant system was going to get the latent
5 issue review and yet your slide has two additional systems
6 on feedwater and emergency generators. Is that as a result
7 of your Phase I and II reviews, adding systems to the Phase
8 III?

9 MR. POWERS: No, on our part we
10 felt that that was an appropriate ovulation of significant
11 systems to look at. And that's based on existing
12 assessments that we've done internally, that we found some
13 areas that we need to look at in more detail, and we're
14 going to look at our feedwater system in more detail.

15 We started out with reactor coolant system because
16 of the work and walkdowns being done in detail there. We
17 want to make sure the overall health of it was very sound.

18 And then the case of the emergency diesel generator,
19 we selected that, because it's important to power supply to
20 the plant. That's additional scope we felt was important
21 to add.

22 As we go through this, we're going to be looking at
23 collective significance of issues that we find. And, if we
24 do one system, that it's difficult to say, if you find an
25 area of maybe a calculation, type of calculation is not

1 rigorous enough, how broad spread is that.

2 But if we were to do three systems, that gives us a
3 better data point to draw a curve, if you will, what is
4 it. Do we have a similar problem in each of the three
5 systems. So, we selected three of our very important
6 systems to do this, a broader picture of what the health
7 is.

8 MR. FAST: Laura, I might
9 clarify. As we did the Phase I, I had talked with Joe
10 Rogers, our Plant Engineer Manager, about the Latent Issues
11 Program, and we had a senior engineer from Beaver Valley
12 come to the site to talk about that program.

13 Early, we committed that the reactor coolant system
14 based on this issue with the reactor head, that that would
15 be appropriate, but we knew we would want to go review and
16 potentially expand that population.

17 MS. COLLINS: Okay, thank you.

18 MR. HOLMBERG: As your plans are
19 developing and you find documentation in your directive
20 issue, you go through the beginning screening process to
21 determine which restart or post-restart, have you developed
22 a standardized set of categories that you call restart?
23 Other plants have done this, where you've got various
24 opinions that, you know, are going to be things that you
25 want to fix for restart and things that are post-restart

1 work. Maybe not got that far?

2 MR. BERGENDAHL: Yes, our restart
3 action has a list of the significant criteria to be used.

4 MR. GROBE: We're at the very
5 earliest stages of developing confidence in what you're
6 doing; and part of that confidence at this point is based
7 on what we read. And, there is a couple of areas where
8 we've heard things today that are different than what we've
9 read in the documents; for example, system walkdowns where
10 appropriate. Well, it's appropriate all the time.

11 We need to have another example as the three
12 systems, which are three excellent systems to be doing your
13 Latent Issues Review on, contrasted with the one.

14 My expectation is we're going to ask you a lot of
15 questions as we have today, and continue as we go through
16 these, such that we develop confidence in the plans that
17 you have. And that's the first step.

18 Of course, you'll be implementing these plans.
19 We'll be inspecting implementation. We'll be looking at
20 the outcome and we'll march forward.

21 I'm wondering if you had plans to update the
22 documents that you've given us to address what you really
23 expect to have happen. And that way we can have confidence
24 in what you have written and, quite frankly, hold you
25 accountable to it.

1 MR. POWERS: Absolutely, and
2 they're tenant documents and we want to get them to you,
3 Jack, to support your O350 processing; so you knew what we
4 were doing and expect us to do.

5 MR. BERGENDAHL: Let me clarify
6 that. We developed plans, went through our internal review
7 process. We've since had them reviewed by our restartup
8 overview board panel. We've gotten some comments from
9 them.

10 Also, as we move from the planning into the
11 discovery phase on several of these plans, we learn some
12 things from our inspections and reviews that fed back into
13 the plan and additional areas that needed to be looked at.

14 So, we will revise these plans as we get that
15 feedback from the independent verification that we're
16 getting and also from our discovery phase. We'll make
17 copies and issue a revision to you as soon as its
18 approved. We'll keep in close communication.

19 MR. GROBE: Another area of
20 difference that I've heard today discussed several times;
21 in the system reviews, the plan talks very clearly about
22 the system engineers doing that work; and program reviews,
23 program owner doing the work. And you've mentioned on a
24 couple of occasions that you're going to have outside
25 assistance in certain areas.

1 I'm not suggesting that that's required. It's your
2 plan. But given the experience with the head degradation,
3 there may be some questions regarding the standards of some
4 of the staff. And you may want to develop assurances that
5 you do have the right standards. And a good way to do that
6 is to get some outside looks in some areas.

7 So, if that was reflected in the plan, then we would
8 have a higher level of confidence that all the right pieces
9 are in there.

10 MR. POWERS: Well, thank you.
11 Those are the plans and I would reflect that in detail in
12 the plan.

13 MR. BERGENDAHL: The restart action
14 plan building block covers all the other building blocks
15 and it shows that each phase that we go through has
16 external independent oversight right from the origination
17 of the plan to the closure of the action item. So, we are
18 utilizing the Davis-Besse expertise, but we're also
19 providing independent oversight through every phase.

20 MR. GROBE: We're coming back
21 to the slides that I suggested that we not talk about
22 several times. Maybe we should have been talking about
23 them, but we'll catch them at another meeting. Those are
24 good points.

25 Any other question on system health?

1 Okay. Can we go on to management and performance
2 area?

3 MR. ESHELMAN: I can do that.

4 I'm David Eshelman, Director of Support Services and
5 I'm author of Management Services Assessment Plan.

6 Our charter was to conduct a thorough assessment,
7 management and organizational issues, and create a
8 comprehensive leadership organizational development plan.

9 As you heard from Randy and Jim, we're looking at
10 structure, systems, components and programs. Each of those
11 however shares a common element, and that's the human
12 element. Humans operate equipment. Humans maintain
13 equipment. Humans write programs and processes. Humans
14 implement the processes.

15 So, we need to look further than just the programs
16 and processes to find out the real issues behind this.

17 We have a lot of good people at the site. All our
18 people are good. They're very highly qualified. Highly
19 trained. They come to work to do a good job. So, when you
20 have something like this, you just can't look at individual
21 human performance, you have to go a lot deeper.

22 Just recently I took the opportunity to do a
23 containment tour, including going underneath the reactor
24 vessel. As I walked around, I saw the conditions, the
25 components, the structures, the systems, but what I realize

1 more importantly was the product of our people. The
2 equipment, the processes are a product of our people, and
3 our people are the product of the organization and
4 management.

5 So, we need to go back to the organizational
6 management to really delve into this issue. Since this is
7 a cross-cutting issue, every program that we've talked
8 about so far, every building block is related to issue and
9 performance, and every building block most likely feeds
10 into human performance plan. So, this is going to be a
11 living document with a lot of input into it.

12 Through the actions of this team, our management
13 organization is committed to maintain a strong safety
14 culture to ensure our Davis-Besse team has a proper focus
15 and tools for success.

16 We're already on the next slide. This plan
17 represents the actions that must be addressed to enhance
18 our employee and public confidence, as well as yours. This
19 plan is sponsored by the Chief Operating Officer who wanted
20 direct involvement with the plan. That's Lew. He wanted
21 to be directly involved. He is the ultimate oversight and
22 approval authority for this plan, as well as the others.

23 That brings up a key point. His presence represents
24 a significant change to our organization. Bob Saunders,
25 the President of FENOC has augmented his corporate staff

1 with the addition of Lew, the Chief Operating Officer, and
2 Lew is devoting full time to Davis-Besse to provide
3 oversight and direction until restart. So he's spending
4 his time at Davis-Besse, as well as the new Chief Operating
5 Officer.

6 We believe, wanted a new vice president of
7 oversight. We created that position for the individual to
8 overlook activities, internal and oversight activities to
9 put more focus on that.

10 We also created an executive position; Executive
11 Vice President for Engineering. As we mentioned
12 previously, this individual was an important senior
13 executive and we just got him this week.

14 Besides the corporate changes, there have been other
15 management changes at the site.

16 Activities completed to-date. First of all, we made
17 some changes to strengthen the organization, internal D-B
18 and also within FENOC.

19 The initial roots and cause analysis report, the one
20 that's on your web page, we had a discussion in Washington
21 on that. We used external personnel for that. We used
22 regional administrators from the Nuclear Regulatory
23 Commission. We used the power outage to start looking at
24 these human factors. And as you saw on that plan, there
25 was some identification of management and organizational

1 issues.

2 Your Augmented Inspection Team. The report from the
3 Augmented Inspection Team identified and characterized the
4 management in the organizational areas. We've had plenty
5 of internal and external reviews of this condition. We've
6 used executives from other facilities recently to come
7 around and interview people and provide us some feedback
8 relative to where we are and what we need to do.

9 Currently in progress, we have the FENOC Quality
10 Assurance Review. The new Vice President of Oversight
11 commissioned a team to look at five condition reports that
12 were identified in the original cause as being
13 characterized as missed opportunities. These were ones
14 where we could have done better to identify the problem.
15 This individual is looking at not only the corrective
16 action process, but how it was implemented and what
17 barriers there were and how that broke down.

18 So, that's a very important review to understand
19 that corrective action process and those specific condition
20 reports.

21 There is personnel feedback. I personally have the
22 opportunity and privilege to go over the root cause
23 timeline and event with all the supervisors. We held
24 approximately four sessions, three complete so far. And
25 what I covered, there is two reasons here why I want to

1 cover the whole timeline.

2 It is very important because this event does not
3 point to a single individual; doesn't point to a single
4 department, organization or team. Essentially it goes over
5 at least a ten-year period. And going through that
6 timeline, it opens our eyes up to the opportunities that we
7 had, the opportunities that we missed, as well as some of
8 the barriers that we could have had in place and didn't.
9 And, the first part is to get the realization to the
10 supervisor or team where we are and how we got there.

11 That's very important to internalize or more for me
12 as a building block. I get feedback from the employees;
13 feedback from the supervisors. And the best way to know
14 about the organization and management is to ask our
15 people. So, I have been getting plenty of feedback during
16 these presentations.

17 The last item going on right now is our formal root
18 cause of the management organizational issues. Lew
19 commissioned an event, and it's to delve deeper than the
20 original cause report and perform detailed root cause of
21 analysis of the nontechnical issues.

22 We're using experts from the industry, human
23 performance experts. We have an expert in root cause of
24 management issues, using a very good system that that
25 person is involved with. This team is getting information

1 from all the other teams, and through their efforts that
2 would be the product that would help us go forward and
3 develop our plans.

4 So, as I mentioned, this plan will have input from
5 the building blocks, a lot of the other activities so far
6 and even some of the ongoing assessment activities.

7 Next slide.

8 To sum it all up, in conclusion and as stated in our
9 Augmented Inspection Team Report. "Management
10 ineffectively implemented processes, and thus failed to
11 detect and address plant problems as opportunities arose."

12 The problems we're talking about is what were
13 identified as missed opportunities we review on the
14 condition reports.

15 Next slide, please.

16 From all the information available, what we have so
17 far is four key focus areas identified. They're the four
18 common contributors coming out of various reviews that we
19 feel need to be addressed. They are ownership, oversight,
20 standards and decision-making. I believe you've heard
21 these items talked about, most of them so far.

22 Ownership, we're looking at program ownership. What
23 it means to be an owner. What your responsibilities are.
24 The people that implement the program, what their
25 responsibilities are. To be successful, we have to be sure